CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/06/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CC	ONSTRUCTION	COMPI	
AND PLAN	OF CORRECTION	155145	A. BUI	LDING		03/17/2	
		100140	B. WIN			03/1//2	.011
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING C	ENTER		1	ST NATIONAL HIGHWAY INGTON, IN47501		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0000	This visit was for Complaint IN000 This visit was in PSR (Post Survey Recertification at Survey and Invest IN00085424 com 2011. Complaint IN000 Federal/state defit	conjunction with the y Revisit) to the ad State Licensure stigation of Complaint appleted on January 27, 187294 - Substantiated. Sciencies related to the sted at F225 and F226. Farch 17, 2011 000068 155145 100274980 TC RN n, RN	F00		FACILITY	ow vey he irm ting	DATE
LABORATOR	Y DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIC	NATURE		TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3BL911

Facility ID:

000068

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		155145	A. BUILDING B. WING		03/17/2011
NAME OF P	PROVIDER OR SUPPLIER	<u>"</u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE ST NATIONAL HIGHWAY	
WASHIN	GTON NURSING C	ENTER		NGTON, IN47501	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E	(X5) E COMPLETION
TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE DATE
	Other: 14				
	Total: 91				
	Sample: 11				
	These deficiencie	es also reflect state			
		accordance with 410 IAC			
	16.2.				
	Quality review 3/23	/11 by Suzanne Williams, RN			

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPL	ETED
		155145	B. WING			03/17/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER			603 EA	ST NATIONAL HIGHWAY		
	GTON NURSING C		WASHINGTON, IN47501				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		· · · · · · · · · · · · · · · · · · ·	E02/	TAG	Submission of this Plan of		DATE
F0225		view and record	F022	25	Correction does not constitute		03/31/2011
SS=D	review, the facility failed to ensure				and admission or an agreemen	nt	
	a resident's (Re	esident #A)			by the provider of the truth of facts alleged or corrections se	4	
	allegation of s	taff verbal and			forth on the statement of		
	physical abuse	e was reported			deficiencies.The Plan of		
		This affected 1 of 5			Correction is prepared and		
	residents revie				submitted because of requirements under State and		
		a sample of 11.			Federal law.Please accept this		
	anegations in a	a sample of 11.			Plan of Correction as our cred	ible	
F: 1: 1				allegation of compliance.F225			
	Findings include:				ABUSE/NEGLECT REPORTE TO ADMINISTRATIONThe fac		
					will ensure this requirement is	·······································	
	Interview of L	PN (charge nurse) #2			met through the following		
	on 03/17/11 at	9:10 a.m. indicated			corrective measures:1. Resid	lent	
	LPN #2 observ	ved therapy working			residents have the potential to	be	
		#A on 03/09/11.			affected. Residents were		
					interviewed as part of the facili	-	
	~ ~	ittempting to get the			investigation and no concerns were noted at this time. 3. The		
	resident to star	nd. LPN #2 indicated			Policy and Procedure for		
	she (LPN #2) a	also was encouraging			Resident Abuse and for Repor	ting	
	the resident to	stand. LPN #2			Unusual Occurrences was		
	indicated CNA	A #3 walked by, and			reviewed and no changes are indicated. The staff have beer	,	
		ointed to the CNA			re-educated on the policies an		
	•	"There she is."			procedures for reporting abuse		
	$\pi(3)$ and said,	THEIR SHE IS.			(See Attachment A). All		
					allegations of abuse will be reported immediately by staff t	_	
	Interview of L	PN #2 on 03/17/11 at			the Administrator. One staff		
	12:20 p.m. ind	licated on 03/09/11			member will be questioned by		
	Resident #A ha	ad eaten breakfast			Administrator or designee daily	y	
	before CNA#	1 and CNA #3			on scheduled work days x4 weeks, then two times weekly	_{x 4}	
		sident. LPN #2			weeks, and then twice monthly		
		DIGOILLE LITTE			thereafter to ensure continued		

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 603 EAST NATIONAL HIGHWAY	COMPLETED 03/17/2011
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 603 EAST NATIONAL HIGHWAY	
603 EAST NATIONAL HIGHWAY	
WASHINGTON NURSING CENTER WASHINGTON, IN47501	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
indicated breakfast was served compliance (See Attachment B).4. The findings of these	
between 8:00 and 9:00 a.m., and the interviews will be reviewed during	ng
resident was taken to therapy at the facility's quarterly Quality Assurance Meetings and the plan	an
approximately 10:00 a.m. LPN #2 of action adjusted accordingly.5.	•
indicated CNA #1 and CNA #3 had The above corrective measures	5
toileted the resident before therapy. will be completed on or before 3/31/11.	
LPN #2 indicated CNA #1 was not	
standing nearby when the resident	
pointed and accused CNA #3. LPN	
#2 indicated CNA #1 did not report	
anything to LPN #2. LPN #2	
indicated the CNAs were aware	
they were supposed to report any	
type of abuse immediately to the	
charge nurse and "for something as	
urgent as this" they definitely	
should report it. LPN #2 said, "I	
am always here (on the unit	
Resident #A) resided and if for	
some reason I am not here they	
know to report it to someone. LPN	
#2 indicated CNA #3 continued to	
work and take care of other	
residents after toileting Resident	
#A.	
An investigative sheet, dated	
03/09/11, indicated, "To whom	

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	OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION	COMPL	
1111212111	or conditions	155145		ILDING		03/17/2	
			B. WI		DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	ST NATIONAL HIGHWAY		
WASHIN	GTON NURSING C	ENTER		WASHIN	NGTON, IN47501		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION DATE
IAG		esident (#A) confided		IAG			DATE
	,	VA #3) was being					
	· ·	is morning during					
		ADL (activities of					
		are. (Resident #A)					
	·	· · · · · · · · · · · · · · · · · · ·					
		his morning when I					
		out of bed they					
	-	is and that (CNA #3)					
	said Jes Chr, if you don't do it now you never will.' I asked (Resident #A) if her belt (gait belt)						
		e said 'yes but the					
	(sic) still pull	•					
		one' (points to CNA					
	· ·	vas in the wash room					
	_	hey were again					
		arms and I keep					
	telling them it	hurts' (sic) (Resident					
	#A) could not	state (CNA #3's)					
	name but when	n passed her in the					
	hall she pointe	ed at her and said 'see					
	there she goes	, get her away from					
	me, I'm afraid	of her." This					
	statement was	signed by LPN #2					
	(Charge Nurse	on the hall where					
	Resident #A re						
	Interview of th	ne Administrator on					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3BL911

Facility ID:

000068 If continuation sheet

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CON	NSTRUCTION		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155145	A. BUI	LDING			COMPL 03/17/2	
		100140	B. WIN				03/11/2	011
NAME OF F	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ST NATIONAL HIG			
WASHIN	GTON NURSING C	ENTER		1	IGTON, IN47501	11 1V V-A T		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN	LOF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED T	CTION SHOULD BE O THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIE	NCY)		DATE
		40 a.m. indicated						
	CNA #3 was re							
	unprofessional	l behavior.						
	Interview of S	peech Therapist #4						
		10:20 a.m. indicated						
	Resident #A was brought to Speech							
		fter being toileted.						
	•	oist #4 indicated, "I						
	could tell (Resident #A) was a little							
	`	if she (Resident #A)						
	•	esident #A) said that						
	`	cribed her and I knew						
	who it was by	the description and						
	-	t#A) said, "Can I						
	,	if there is a sheet."						
	_	oist #4 indicated to						
		at she would help her						
		t. Speech Therapist						
		nat she wrote exactly						
		ent said that (CNA						
		pper) arm and talked						
	,	Speech Therapist #4						
		A #3 walked by and						
		ointed at CNA #3 and						
	said,"there she							
		ndicated she went						
	_	her supervisor and						
		1 "						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	3BL911	Facility II	D: 000068	If continuation sh	neet Pa	ge 6 of 42

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 03/17/2011		
	PROVIDER OR SUPPLIER		603 EA	ADDRESS, CITY, STATE, ZIP CODE ST NATIONAL HIGHWAY NGTON, IN47501	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
MG	her supervisor reported to the charge nurse we CNA #3. Special indicated she that and when she cout of the build. Therapist #4 in told her that she was too weak #3 said, "yes yes." A copy of a "Coprovided by that 11:00 a.m. "PT (Resident from ST (Special form Contain the cout form Contain the cout form Contain the cout form where she states staff me yes you can deter that her legs we contain the cout form the cout form where she states staff me yes you can determined her that her legs we contain the cout form the cout form where she states staff me yes you can determined her that her legs we contain the cout form the cout for	immediately charge nurse and the vent immediately to ech Therapist #4 hen went to lunch returned CNA #3 was ding. Speech indicated the resident ne told CNA #3 she to stand up and CNA rou can, yes you can." Concern Form" was ne DON on 03/17/11 This form indicated, #A) requested assist ech Therapy) to fill incern: Pt (Resident plained of) nursing				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/17/2011		
		100170	B. WIN		DDDECC CITY CTATE ZID CODE	03/17/2	V 1 1
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ST NATIONAL HIGHWAY		
	GTON NURSING C			WASHII	NGTON, IN47501		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	happens 'over	& over' & believes					
	'action' needs t	to take place.					
	Department's r	response: Listen to					
	patient's (Resid	dent #A's)					
	complaints. R	eported to					
	department nu	rse & rehab					
	managerPt u	nable to state aid's					
	name but wa	s able to describe and					
	point out specific aid."						
		hysical Therapy					
	`	A) #5 on 03/17/11 at					
		icated, the only thing					
	she was aware	of was when staff					
	attempted to w	valk Resident #A the					
	resident didn't	want to walk. PTA					
	#5 indicated th	ne resident had					
	*	n progressing well.					
		ted CNA#3 walked					
	~	nt #A said, "There					
	ĺ	e is, she doesn't want					
	to help me."						
	Intomviore	lautified Occurration					
		tertified Occupation					
	1	tant (COTA) #6 on :30 a.m. indicated the					
		een toileted and then					
	came to therap	by. CO1A #0					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE : COMPL	
		155145	A. BUILDI B. WING	ING		03/17/2	011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
					ST NATIONAL HIGHWAY		
	GTON NURSING C				IGTON, IN47501		ars)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	indicated Resi	dent #A told her,					
	"Oh, honey th	at girl was mean. She					
	talked mean &	she hurt my arm.					
	They need to g	give me more time."					
	COTA #6 indi	cated she asked					
	Resident #A w	ho she was talking					
	about and aske	ed her to give some					
	examples. CC	OTA #6 indicated the					
		she pulled my arm."					
	COTA #6 indi						
	described who	the "girl" was.					
		cated she tried to					
	walk the resid	ent and the resident					
	stood up and (CNA #3 walked by					
	and the reside	nt indicated, "Oh my					
	G-d honey the	re she is. She's the					
	one." COTA#	#6 indicated the					
	resident was the	nen taken back to her					
	room.						
		ve sheet, dated					
	l '	cated, "On this date,					
	'	reported some					
	_	er the CNAs toileted					
	'	dent #A) stated 'that					
		rough with me and					
		ne by my arms.					
	Shortly after the	hese statements					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	1 '	E SURVEY PLETED
		155145	A. BUILDING B. WING		03/17/	
NAME OF I	PROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING C	ENTER	WAS	HINGTON, IN47501		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
PREFIX	REGULATORY OR (Resident #A) ambulate. (CN the hall and (R pointing sayin her!' This inci presence of (C #5, and LPN # (Resident #A) (walk) 20 ft, h and fearful that her (sic) also s assist of 2 to s (walk). (Resid therapists that to someone ab Therapist assis filling out con- reported to Re Interview of th Nursing (DON 10:40 a.m. ind previous incid who was trans facility but it w said" so was n DON indicated	was in the hallway to NA#3) walked down desident #A) started g 'there she is, that's dent was in the OTA #6, ST #4, PTA (2). Up to this date had been able to owever was so upset at therapist would hurt he required max tand and unable to she would like to talk out these concerns. Sted (Resident #A) in cern form and hab nurse (LPN #2)." The Director of an another was a "he said, she ot validated. The d CNA #3 had		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE	COMPLETION
	problems in th	e past where she				

	OF CORRECTION	IDENTIFICATION NUMBER:			INSTRUCTION	(X3) DATE	SURVEY LETED
		155145	I	ILDING NG		03/17/2	
			B. WI		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	ST NATIONAL HIGHWAY		
WASHIN	GTON NURSING C	ENTER		WASHII	NGTON, IN47501		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
		thy with staff in front					
		s, but would be					
		then "would settle					
	down." The D	ON indicated, "This					
	is the first time	e I've had a resident					
	point someone	out to me and say,					
	"she did this."	The DON indicated					
	the abuse occu	irred in the shower					
	room and CNA	A #1 was present					
	when it happer	ned. The DON					
	indicated CNA	A #1 did not report the					
	abuse. The Do	ON indicated therapy					
	came to her an	d reported what the					
	resident said.	The DON indicated					
	she was told by	y CNA #1 that the					
	CNA said she	was afraid to report					
	what happened	d. The DON					
	indicated the r	esident was confused					
	but she told the	e same story 3 times.					
	The DON indi	cated the resident had					
	a bruise on her	arm which looked					
	like a "hand pr	rint" bruise. The					
	DON indicated	d the CNA #3 denied					
	it (Resident #A	A's allegation) but "I					
	felt like it prob	oably happened."					
	The DON indi	cated she notified the					
	Adult Protective	ve Services (APS),					
	the Ombudsma	an, and ISDH, but did					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED 03/17/2011		
		155145	B. WIN			_	03/17/20	711
	PROVIDER OR SUPPLIER			603 EAS	.ddress, city, state, z ST NATIONAL HIGH NGTON, IN47501			
(X4) ID		TATEMENT OF DEFICIENCIES	-1	ID	·			(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO DEFICIENC	ION SHOULD BE THE APPROPRIATE	<u> </u>	COMPLETION DATE
1710		occurrence to the		1710		<u> </u>	1	DAIL
	1	The DON indicated						
		right to her (the						
	DON) and CNA #3 was brought to							
	'	locked out. The DON						
	indicated Resi	dent #A required a lot						
		rom staff and was						
	confused and	by the afternoon the						
		not remember what						
	happened, but when asked if she							
	was afraid of a	anything she said						
	only that 1 gi	rl." The DON						
	indicated a de	pression scale was						
	completed on	Resident #A that						
	afternoon and	her depression scale						
	had increased	since the last						
	depression sca	le. The DON						
	indicated she	verbally told CNA #1						
	that she should	d always report any						
	abuse or allega	ation of abuse to her						
	charge nurse.	The DON indicated						
	she (the DON)) had gone to CNA #1						
	for questionin	g regarding the						
	resident's alleg	gation. The DON						
	indicated the (CNA had not told						
	anyone.							
	Interview of C	ENA #1 on 03/17/11 at						
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		155145	A. BUILDI B. WING	NG		03/17/2	
NAME OF I	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
			603 EAST NATIONAL HIGHWAY				
	GTON NURSING C				NGTON, IN47501		(ME)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	Т	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.IE	DATE
	2:05 p.m. indi	cated, "Me (CNA #1)					
	and (CNA #3)	were taking					
	(Resident #A)	to the bathroom and					
	(CNA #3) was	s yanking on					
	(Resident #A)	with the gait belt.					
	l ` ′	nt to (answer) an					
		en she came back -					
		k told (Resident #A)					
	to 'stand her F	ug a-s up.' Then					
	she (CNA #3)	told the resident she					
	could stand up	and pull her pants					
	up herself. Ci	NA #1 indicated after					
	toileting the re	esident, she took the					
	resident (in the	e resident's					
	wheelchair) ba	ack to the nurse's					
	station. (The r	nurse's station is an					
	enclosed area	with a window in the					
	front.) CNA#	3 indicated the nurse					
	(LPN #2) "wa	s in there but					
	someone was	with her." CNA #3					
		did not report the					
		the nurse but told the					
	resident to tell	the nurse.					
	_	ve sheet (not dated)					
	,	CNA #1) was in the					
	· '	CNA#3) when (CNA					
	#3) told (Resid	dent #A) she was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY COMPLETED		
AND PLAN	and Plan of Correction identification number: 155145			LDING			03/17/2		
		1661.16	B. WIN		DDRESS, CITY, STATE,	ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	R		1	T NATIONAL HIGI				
WASHIN	GTON NURSING C	CENTER		WASHIN	IGTON, IN47501				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT			(X5)	
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIAT	E	COMPLETION DATE	
		a hold of the gait belt							
		did (Resident #A)							
		use) she (CNA #3)							
	moved her foot. So then (CNA #3)								
		d said she was tired of							
	residents treat	in (sic) her like sh-t							
		ways get the blame							
	for everything	g. Also she (CNA #3)							
	told (Resident	#A) on our second							
	attempt to star	nd her up that we							
	could not help	her stand (sic) we							
	could only use	e and hold onto the							
	gait belt. She	(CNA #3) said we							
	don't have fu-	-ing time for this							
	because we ha	eve other people to get							
	up. So she tol	d her (Resident #A)							
	again after we	sat her down again.							
	(sic) To stand	up, pull up her pants,							
	and to get into	her chair by herself,							
	since she (Res	sident #A) thinks she							
	can do everyth	ning herself! Then							
	she said she d	idn't have times (sic)							
	for games so v	we stood her up and							
	pulled up her	pants and put her in							
	her chair! So t	then we took her out							
	for breakfast.	After we transferred							
	her (Resident	#A) to the toilet (sic)							
	(CNA #3) left	(Resident #A) in the							
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	3BL911	Facility II	D: 000068	If continuation sh	eet Pa	ge 14 of 42	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPLETI	
		155145	B. WIN			03/17/201	1
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING C	ENTER		1	ST NATIONAL HIGHWAY NGTON, IN47501		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE C	OMPLETION DATE
1110		me (CNA #1) for a		1110			DITTE
	minute because she had to answer						
	an alarm and (Resident #A) asked					
	me (why) (CN	(A#3) was always this					
	way towards h	er and how come she					
	was hateful. I	(CNA #1) told her I					
	really didn't kı	now but that she					
	should tell her	nurse when someone					
	doesn't treat he	er right because that					
	wasn't fair to l	ner and that she					
	doesn't derserv	ve (sic) to be treated					
	bad."						
	Copies of inve	estigative sheets					
	related to the o	occurrence on					
	03/09/11 with	CNA #3 and					
	Resident #A w	vere provided by the					
	DON on 03/17	7/11 at 11:00 a.m.					
	Interview of L	PN #2 on 03/17/11 at					
	1:50 p.m. indi	cated, "(CNA#1) had					
	the opportunit	y to tell me (what					
	took place wit	h CNA #3 and					
	Resident #A). LPN #2 indicated						
	she (LPN #2) was there. LPN #2 indicated if she hadn't been there						
	the CNA shou	ld have told another					
	nurse. LPN #2	2 indicated she first					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/17/2011		
		155145	B. WIN	_		03/17/2	2011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING C	ENTER		1	ST NATIONAL HIGHWAY NGTON, IN47501		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	COMPLETION DATE
	found out whe	n the Therapy					
		as attempting to get					
	the resident to						
	indicated she a	also was trying to					
ı	encourage the	resident to stand and					
	Resident #3 ke	ept saying 'I'm afraid,					
	I'm afraid.' LF	N #2 indicated					
	CNA#3 had be	een taking care of					
	other residents	and walked by					
	(Resident #A)	and the resident					
	pointed out to	(CNA #3) and said					
	she was afraid	of this CNA.					
	Interview of R						
		:00 p.m. indicated the					
		was going fine. The					
		miling and cheerful at					
		interview. The					
		ted there was one					
	_	ked mean. She had					
		coming out of her					
		as mad every time she					
		came in with a bad					
		resident indicated, "I					
	•	ired heryou need					
		riew and go through					
	it." The reside	ent indicated at the					
	present time, "	All the girls are real					
			-				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/17/2011	
		100140	B. WIN		DDDDGG GENV GENT GEN GOT	03/17/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ST NATIONAL HIGHWAY		
	GTON NURSING C	ENTER		1	NGTON, IN47501		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG		CROSS-REFERENCED TO THE APPROPRIATE	
	nice."						
	A community "E	AV/INCIDENT					
	A copy of a "FAX/INCIDENT REPORT" form was provided by						
		3/17/11 at 11:00 a.m					
		licated, "Incident					
	1	1Staff noted a					
		mately 14x11 cm					
		on resident's upper					
	l '	g care. Resident was					
	·	22/11 with edema,					
	severe/extensive	· · · · · · · · · · · · · · · · · · ·					
		numerus (arm), and a					
		nip as a result of a fall					
		sion. The resident is					
	_	t term memory					
	impairment an	•					
	confusion. Up	oon interview,					
	resident denies	s any injury to left					
	armThe Adr	ministrator and					
	Director of Nu	rsing were notified					
	as well as the	Physician and family.					
	The resident w	as assessed for pain.					
	Interviews of s	staff working on this					
	wing were init	iated. In speaking					
	with the family	y, they stated that					
	(Resident #A)	bruises very easily					
	and has always	s done so. Preventive					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPLE	
		155145	B. WIN	G		03/17/20	11
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	•	
				1	ST NATIONAL HIGHWAY		
WASHIN	GTON NURSING C	ENIER		WASHII	NGTON, IN47501		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTIP PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
1110		en: The Director of		1710			DITTE
	Nursing or designee will monitor						
	transfers of the resident and speak						
	with Physical	Therapy and					
ı	Occupational '	Therapy to try to					
	determine a ca	use. The resident is					
	to have a CBC	C (complete blood					
	count) and X-1	ray done on 3/7/11.					
	This report co	py was the "initial					
	Report."						
	•						
	A copy of a "	FAX/INCIDENT					
	REPORT" for	m was provided by					
		3/17/11 at 1:00 p.m.					
	This report wa	is a repeat of the					
	above incident	t on 03/06/11. This					
	report had add	litional information					
	which include	d, "During					
		period, resident					
		one employee was					
	1 *	er and had used her					
	~	er her causing pain in					
		lent stated that she					
	was uncomfor						
	Q.M.A. (Qual						
		NA #3 was also a					
	/ \	ing ADL care on her.					
	_ ´ *	rted to have occurred					
	11115 Was 10po	itoa to nave occurred					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Ì	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155145	A. BUII B. WIN			03/17/2011		
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	p. ,, n.	STREET A	DDRESS, CITY, STATE, ZIP CODE	<u> </u>		
WASHIN	GTON NURSING C	ENTER	603 EAST NATIONAL HIGHWAY WASHINGTON, IN47501					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	4010IN, IIN+7001		(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΔTE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE	
		g of 3/9/11. Further						
	investigation i							
	allegation dire							
	the bruise on l							
		physical therapy,						
		nd co-worker were						
		This report copy was						
	the "Follow-up	p Keport."						
	A copy of a fo	rm titled "NOTICE						
	A copy of a form titled "NOTICE OF DISCIPLINARY ACTION,"							
	dated 03/09/11	,						
		CCNA #3. The form						
	indicated, "#							
	allegation of v	-						
	physical misco							
		ng fear from resident.						
		ritten warnings on						
	_	6/3/08 - attitude,						
		e to comply with						
		ions for performance						
	^	t forth in employee						
	Handbook.							
		al/inappropriate						
	_	nd residents (with)						
		that further incidents						
	_	ermination. Describe						
	*	nation you have						
		•						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145			(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION	(X3) DATE COMP 03/17/2	LETED
	PROVIDER OR SUPPLIER		603 EA	ADDRESS, CITY, STATE, ZIP CODE ST NATIONAL HIGHWAY NGTON, IN47501		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) The supports taking the	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	above course of #A's) allegation verbal inapprosame resident bruising of rig expresses fear. Review of Resident #A horizontal minimal properties and the fear record on 03/1 indicated horizontal fear record in the fear record of falls 1/19/11, peripherical fear record in the	ad diagnoses which were not limited to, ctive pulmonary arthritis, dementia, s, left hip fracture heral vascular nic oxygen use, and bleed.				
	and toileting.					

PRINTED: 04/06/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155145	A. BUIL B. WING			03/17/2	011
	PROVIDER OR SUPPLIER			603 EAS	DDRESS, CITY, STATE, ZIP CODE ST NATIONAL HIGHWAY NGTON, IN47501		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤΕ	(X5) COMPLETION DATE
	Enterprises Pro-Abuse" was pro-on 03/17/11 at policy indicate assure approprian place and for abuse is susperidentifiedPro-abuse, or suspereported: 1. To involved in the removed from onceThe individual shall notify any other duty. The charge nurse is charge nurse is susperior to the pro-occurred and to charge nurse is susperior to the susperior to the individual shall notify any other duty. The charge nurse is susperior to the susperior to the pro-occurred and to the susperior to the pro-occurred and the charge nurse is susperior to the s	cocedure: If resident icion of abuse is The resident(s) is incident will be the situation at ividual who incident shall otify a charge nurse unit which the ies. If this is not icircumstances, the libe responsible to the er nurse currently on					

000068

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155145			LDING	NSTRUCTION	(X3) DATE : COMPL 03/17/2	ETED
	PROVIDER OR SUPPLIER		 603 EAS	DDRESS, CITY, STATE, ZIP CODE ST NATIONAL HIGHWAY NGTON, IN47501	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	implicated in the bear to be removed from	Any staff member the alleged abuse will om the facility at remain suspended igation is				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 155145 03/17/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 603 EAST NATIONAL HIGHWAY WASHINGTON NURSING CENTER WASHINGTON, IN47501 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE F226 DEVELOP/IMPLEMENT F0226 F0226 03/31/2011 Based on interview and record POLICIES/PROCEDURES SS=D review, the facility failed to ensure **PREVENT** a resident's (Resident #A) MISTREATMENT/NEGLECT/AB USEThe facility will ensure this allegation of staff verbal and requirement is met through the physical abuse was reported following corrective measures:1. Resident #A was not harmed.2. immediately according to facility All residents have the potential to policy and procedures. This be affected. Residents were interviewed as part of the facility's affected 1 of 5 residents reviewed investigation and no concerns for abuse allegations in a sample of were noted at this time. 3. The Policy and Procedure for 11. Resident Abuse and for Reporting Unusual Occurrences was Findings include: reviewed and no changes are indicated. The staff have been re-educated on the policies and Interview of LPN (charge nurse) #2 procedures for reporting abuse (See Attachment A). All on 03/17/11 at 9:10 a.m. indicated allegations of abuse will be LPN #2 observed therapy working reported immediately by staff to the Administrator. One staff with Resident #A on 03/09/11. member will be questioned by the Therapy was attempting to get the Administrator or his designee daily on scheduled work days x4 resident to stand. LPN #2 indicated weeks, then two times weekly x 4 she (LPN #2) also was encouraging weeks, and then twice monthly the resident to stand. LPN #2 thereafter to ensure continued compliance (See Attachment indicated CNA #3 walked by, and B).4. The findings of these Resident #A pointed to the CNA interviews will be reviewed during the facility's quarterly Quality #(3) and said, "There she is." Assurance Meetings and the plan of action adjusted accordingly.5. The above corrective measures Interview of LPN #2 on 03/17/11 at will be completed on or before 12:20 p.m. indicated on 03/09/11 3/31/11. Resident #A had eaten breakfast

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N	MULTIPLE CO	NSTRUCTION	(X.	3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155145		ILDING		_ ,	03/17/2011
		100170	B. WII		DDDECC CITY CTATE CITY		55, 17,2011
NAME OF F	PROVIDER OR SUPPLIER	1			.DDRESS, CITY, STATE, ZIP C ST NATIONAL HIGHWA		
WASHIN	GTON NURSING C	ENTER		1	NGTON, IN47501	VI	
(X4) ID		TATEMENT OF DEFICIENCIES		ID		OVIDER'S PLAN OF CORRECTION	
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETION DATE
mo	before CNA #1		′ 	mo			DATE
		sident. LPN #2					
		kfast was served					
		and 9:00 a.m., and the					
		aken to therapy at					
		1.0					
	approximately 10:00 a.m. LPN #2 indicated CNA #1 and CNA #3 had						
toileted the resident before therapy.							
		ated CNA #1 was not					
		by when the resident					
	_	ccused CNA #3. LPN					
	•	CNA #1 did not report					
		PN #2. LPN #2					
	, ,	CNAs were aware					
		posed to report any					
		immediately to the					
		and "for something as					
	C	they definitely					
	_	it. LPN #2 said, "I					
	am always her						
	_	resided and if for					
	•	am not here they					
		t it to someone. LPN					
	_	CNA #3 continued to					
	work and take						
		toileting Resident					
	#A.	tonethig Kesident					
	πA .						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	3BL911	Facility I	D: 000068 If con	tinuation shee	t Page 24 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155145	A. BUII B. WIN			03/17/2	011
NAME OF I	PROVIDER OR SUPPLIER		<u>I</u>	STREET A	DDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING C	ENTER	603 EAST NATIONAL HIGHWAY WASHINGTON, IN47501				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
		ve sheet, dated		0			5.112
	03/09/11, indi	cated, "To whom					
	concerned, Re						
	in me that (CN	NA #3) was being					
	mean to her th	is morning during					
	transfers and A	ADL (activities of					
	l 2	are. (Resident #A)					
		his morning when I					
	0 0 1	out of bed they					
	1 *	as and that (CNA #3)					
	said Jes Chr-	, if you don't do it					
	now you never	r will.' I asked					
	(Resident #A)	if her belt (gait belt)					
	was on and sh	e said 'yes but the					
	(sic) still pull	on my arms					
	especially that	one' (points to CNA					
	#3). 'When I w	vas in the wash room					
	this morning the	hey were again					
	pulling on my	arms and I keep					
	telling them it	hurts' (sic) (Resident					
	#A) could not	state (CNA #3's)					
	name but when	n passed her in the					
	hall she pointe	ed at her and said 'see					
	there she goes	, get her away from					
	me, I'm afraid	of her." This					
	statement was	signed by LPN #2					
	(Charge Nurse	e on the hall where					
	Resident #A re	esided).					
	<u> </u>						

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		(X3) DATE COMPL	
		155145	A. BUII B. WIN				03/17/2	011
			B. WIN		DDRESS, CITY, STATE,	ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ST NATIONAL HIG			
WASHIN	GTON NURSING C	ENTER		WASHIN	IGTON, IN47501			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN			(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED T DEFICIE	O THE APPROPRIAT	ΓE	COMPLETION DATE
mo	REGULTION ON	ESC IDENTIFY THO INTO COMMITTEE TO		1110				Bittl
	Interview of the	ne Administrator on						
		10 a.m. indicated						
	CNA #3 was released for							
	unprofessional behavior.							
	Interview of S	peech Therapist #4						
	on 03/17/11 at 10:20 a.m. indicated							
	Resident #A was brought to Speech							
	Therapist #4 after being toileted.							
	Speech Therapist #4 indicated, "I							
	1 ^ ^	sident #A) was a little						
	`	if she (Resident #A)						
	_	esident #A) said that						
	`	eribed her and I knew						
		the description and						
	· ·	#A) said, "Can I						
	`	if there is a sheet."						
	_	oist #4 indicated to						
	^ -	at she would help her						
		t. Speech Therapist						
	_	nat she wrote exactly						
		ent said that (CNA						
		pper) arm and talked						
	l '	Speech Therapist #4						
		A #3 walked by and						
		•						
	said,"there she	ointed at CNA #3 and						
	saiu, meie sne	is. Specul						
FORM CMS-2	2567(02-99) Previous Versio	ons Obsolete Event ID:	3BL911	Facility II	D: 000068	If continuation s	neet Pa	ge 26 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155145	B. WIN			03/17/2	011	
	PROVIDER OR SUPPLIER		•	603 EAS	DDRESS, CITY, STATE, ZIP CODE ST NATIONAL HIGHWAY	•		
	GTON NURSING C			<u>L</u> .	NGTON, IN47501			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE	
PREFIX	Therapist #4 in immediately to her supervisor reported to the charge nurse we CNA #3. Special indicated she that and when she cout of the build to the that she was too weak #3 said, "yes yes yes a copy of a "Coprovided by that 11:00 a.m." PT (Resident from ST (Special immediately a provided by the state of the she was too weak #3 said, "yes yes yes yes yes yes yes yes yes yes	cy Must be perceded by full Lisc identifying information) indicated she went of her supervisor and immediately a charge nurse and the went immediately to each Therapist #4 then went to lunch returned CNA #3 was ding. Speech indicated the resident me told CNA #3 she to stand up and CNA fou can, yes you can." Concern Form" was the DON on 03/17/11 This form indicated, #A) requested assist each Therapy) to fill		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	NTE .	COMPLETION	
	#A) C/O (com aid grabbing h 'throwing me' mean.' C/O pa arm where she states staff me yes you can do	plained of) nursing er by arms & onto toilet & 'talking in on (right) upper was 'grabbed.' Pt mber says 'Stand Up'! o it! Pt states she has legs are very weak &						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE COMP 03/17/2	LETED	
NAME OF PROVIDER WASHINGTON N			603 EA	ADDRESS, CITY, STATE, ZIP CODE ST NATIONAL HIGHWAY INGTON, IN47501	 	
TAG REG	CH DEFICIEN ULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRODEFICIENCY)) BE	(X5) COMPLETION DATE
emotic happed 'action' Department patier computer computer department name point. Interv. Assist 10:25 she we attem resided #5 indeprevious PTA # by an she is to hell. Interv. Thera	ional and ens 'over n' needs to rtment's int's (Residents. Retment nurgerPt urbut was out specified to went didn't dicated thously been to deside the total of the test of	crying & states this & over' & believes to take place. response: Listen to dent #A's) eported to rse & rehab nable to state aid's s able to describe and ific aid." hysical Therapy A) #5 on 03/17/11 at icated, the only thing of was when staff valk Resident #A the want to walk. PTA he resident had en progressing well. ted CNA#3 walked ent #A said, "There he is, she doesn't want rertified Occupation tant (COTA) #6 on :30 a.m. indicated the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155145	B. WIN	_		03/17/2	U11
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING C	ENTER		1	ST NATIONAL HIGHWAY NGTON, IN47501		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
PREFIX TAG	, i	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG		ROSS-REFERENCED TO THE APPROPRIATE	
	resident had be	een toileted and then					
	came to therap	y. COTA#6					
indicated Resident #A told her,							
	"Oh, honey that girl was mean. She						
	talked mean &	she hurt my arm.					
	'	give me more time."					
	COTA #6 indicated she asked						
	Resident #A w	ho she was talking					
	about and asked her to give some						
	examples. COTA #6 indicated the						
	resident said "	she pulled my arm."					
	COTA #6 indi	cated the resident					
	described who	the "girl" was.					
	COTA #6 indi	cated she tried to					
	walk the reside	ent and the resident					
	stood up and C	CNA #3 walked by					
		nt indicated, "Oh my					
	1	re she is. She's the					
		f6 indicated the					
	resident was th	nen taken back to her					
	room.						
	An investigativ	ve sheet, dated					
		cated, "On this date,					
	ĺ	reported some					
	·	er the CNAs toileted					
	_	dent #A) stated 'that					
	'	rough with me and					

NAME OF PROVIDER OR SUPPLIER WASHINGTON NURSING CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 603 EAST NATIONAL HIGHWAY WASHINGTON, IN47501 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COM		
NAME OF PROVIDER OR SUPPLIER WASHINGTON NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	03/17/2011	
PROVIDER'S PLAN OF CORRECTION		
CROSS-REFERENCED TO THE APPROPRIATE	(X5) MPLETION DATE	
always grabs me by my arms. Shortly after these statements (Resident #A) was in the hallway to ambulate. (CNA#3) walked down the hall and (Resident #A) started pointing saying 'there she is, that's her!' This incident was in the presence of (COTA #6, ST #4, PTA #5, and LPN #2). Up to this date (Resident #A) had been able to (walk) 20 ft, however was so upset and fearful that therapist would hurt her (sic) also she required max assist of 2 to stand and unable to (walk). (Resident #A) reported to therapists that she would like to talk to someone about these concerns. Therapist assisted (Resident #A) in filling out concern form and reported to Rehab nurse (LPN #2)." Interview of the Director of Nursing (DON) on 03/17/11 at 10:40 a.m. indicated CNA #3 had a previous incident with a gentleman who was transferred to another facility but it was a "he said, she said" so was not validated. The	DATE	

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CON	NSTRUCTION		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155145	1	LDING			COMPL 03/17/2	
		100170	B. WIN		DDRESS, CITY, STATE	ZID CODE	1 00/11/2	
NAME OF I	PROVIDER OR SUPPLIEF	R		1	DDRESS, CITY, STATE ST NATIONAL HIC			
	GTON NURSING C			1	IGTON, IN47501			
(X4) ID		STATEMENT OF DEFICIENCIES		ID		N OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP DEFICIENCY)		TE	COMPLETION DATE
	DON indicate	d CNA #3 had						
	problems in th	ne past where she						
	would be mou	thy with staff in front						
	of the resident	s, but would be						
	counseled and	then "would settle						
	down." The I	OON indicated, "This						
	is the first tim	e I've had a resident						
	point someone	e out to me and say,						
	"she did this."	The DON indicated						
	the abuse occu	irred in the shower						
	room and CNA							
	when it happe							
	indicated CNA	A #1 did not report the						
	abuse. The D	ON indicated therapy						
	came to her ar	nd reported what the						
	resident said.	The DON indicated						
	she was told b	y CNA #1 that the						
	CNA said she	was afraid to report						
	what happened	d. The DON						
	indicated the r	resident was confused						
	but she told th	e same story 3 times.						
	The DON indi	icated the resident had						
	a bruise on he	r arm which looked						
	like a "hand pa	rint" bruise. The						
	DON indicate	d the CNA #3 denied						
	it (Resident #A	A's allegation) but "I						
	felt like it prol	bably happened."						
	The DON indi	icated she notified the						
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155145	B. WIN	_		03/17/20	U11
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING C	ENTER		1	ST NATIONAL HIGHWAY NGTON, IN47501		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION DATE
1710		ve Services (APS),	-	ING	·		DATE
		an, and ISDH, but did					
not report the occurrence to the							
	_	The DON indicated					
		right to her (the					
	1 1	A #3 was brought to					
	her also and clocked out. The DON						
	indicated Resident #A required a lot						
	of assistance from staff and was						
	confused and by the afternoon the						
	resident could not remember what						
		when asked if she					
		nything she said					
	"only that 1 gi						
	'	pression scale was					
	_	Resident #A that					
	_	her depression scale					
	had increased	•					
	depression sca	le. The DON					
	_	verbally told CNA #1					
		d always report any					
		ation of abuse to her					
	_	The DON indicated					
	_	had gone to CNA #1					
	for questioning	g regarding the					
	resident's alleg	gation. The DON					
	indicated the C	CNA had not told					
	anyone.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155145	B. WIN	_		03/17/2	U11
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ST NATIONAL HIGHWAY		
_	GTON NURSING C			<u>L</u> .	NGTON, IN47501		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤΕ.	DATE
	Interview of C 2:05 p.m. indic and (CNA #3) (Resident #A) (CNA #3) was (Resident #A) (CNA #3) wen alarm and whe she point bland to 'stand her Fr she (CNA #3) could stand up up herself. CN toileting the re resident (in the wheelchair) ba station. (The n enclosed area of front.) CNA#3 (LPN #2) "was someone was we indicated she co occurrence to the	NA #1 on 03/17/11 at cated, "Me (CNA #1) were taking to the bathroom and yanking on with the gait belt. It to (answer) an en she came back - k told (Resident #A) ug a-s up.' Then told the resident she and pull her pants NA #1 indicated after esident, she took the eresident's ack to the nurse's urse's station is an with a window in the 3 indicated the nurse is in there but with her." CNA #3 did not report the the nurse but told the					

STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155145			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155145	B. WIN		<u> </u>	03/17/2	011
NAME OF I	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE	•	
	GTON NURSING C			1	ST NATIONAL HIGHWAY NGTON, IN47501		
				ID	(V5)		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE.	DATE
	shower with (0	CNA#3) when (CNA					
	#3) told (Resid	lent #A) she was					
	going to grab a	a hold of the gait belt					
	and when she did (Resident #A)						
	had a fit (becar	use) she (CNA #3)					
	moved her foo	t. So then (CNA #3)					
	stood back and said she was tired of						
	residents treatin (sic) her like sh-t						
	and that we always get the blame						
	for everything. Also she (CNA #3)						
	told (Resident	#A) on our second					
	attempt to stan	nd her up that we					
	could not help	her stand (sic) we					
	could only use	and hold onto the					
	gait belt. She	(CNA #3) said we					
	don't have fu	ing time for this					
	because we ha	ve other people to get					
	up. So she tole	d her (Resident #A)					
	again after we	sat her down again.					
	(sic) To stand	up, pull up her pants,					
	and to get into	her chair by herself,					
	since she (Res	ident #A) thinks she					
	can do everyth	ing herself! Then					
	she said she di	dn't have times (sic)					
	for games so v	ve stood her up and					
	pulled up her p	pants and put her in					
	her chair! So t	hen we took her out					
	for breakfast.	After we transferred					

NAME OF PROVIDER OR SUPPLIER WASHINGTON NURSING CENTER A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 603 EAST NATIONAL HIGHWAY WASHINGTON, IN47501)11
WASHINGTON NURSING CENTER 603 EAST NATIONAL HIGHWAY WASHINGTON, IN47501	
(VALID SUMMARY STATEMENT OF DEFICIENCIES ID	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
her (Resident #A) to the toilet (sic) (CNA #3) left (Resident #A) in the bathroom with me (CNA #1) for a minute because she had to answer an alarm and (Resident #A) asked me (why) (CNA#3) was always this way towards her and how come she was hateful. I (CNA #1) told her I really didn't know but that she should tell her nurse when someone doesn't treat her right because that wasn't fair to her and that she doesn't derserve (sic) to be treated bad." Copies of investigative sheets related to the occurrence on 03/09/11 with CNA #3 and Resident #A were provided by the DON on 03/17/11 at 11:00 a.m. Interview of LPN #2 on 03/17/11 at 1:50 p.m. indicated, "(CNA#1) had the opportunity to tell me (what took place with CNA #3 and Resident #A). LPN #2 indicated she (LPN #2) was there. LPN #2 indicated if she hadn't been there	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	IULTIPLE CO	NSTRUCTION		(X3) DATE : COMPL	
		155145		LDING			03/17/2011	
			B. WIN		DDRESS, CITY, STATE, Z	IP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R		1	ST NATIONAL HIGH			
WASHIN	GTON NURSING C	ENTER		WASHIN	IGTON, IN47501			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN O			(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)		ΓE	COMPLETION DATE
		ld have told another		mo				DINE
		2 indicated she first						
		en the Therapy						
		as attempting to get						
	•	stand. LPN #2						
ı	indicated she	also was trying to						
		resident to stand and						
	Resident #3 kg	ept saying 'I'm afraid,						
		PN #2 indicated						
	CNA#3 had be	een taking care of						
	other residents							
	(Resident #A)	and the resident						
	pointed out to	(CNA #3) and said						
	she was afraid	of this CNA.						
	Interview of R	Resident #A on						
	03/17/11 at 12	:00 p.m. indicated the						
	resident's care	was going fine. The						
	resident was s	miling and cheerful at						
	the time of the	e interview. The						
	resident indica	ated there was one						
	"girl" who "ta	lked mean. She had						
	terrible words	coming out of her						
	mouthshe w	as mad every time she						
	came in. She	came in with a bad						
	attitude." The	resident indicated, "I						
	told and they	fired heryou need						
	to take this rev	view and go through						
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155145	B. WIN			03/17/20	J11
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ST NATIONAL HIGHWAY		
WASHIN	GTON NURSING C	ENTER		1	NGTON, IN47501		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
		ent indicated at the					
	present time, "All the girls are real						
	nice."						
	A copy of a "FAX/INCIDENT REPORT" form was provided by						
		3/17/11 at 11:00 a.m					
	This report inc	licated, "Incident					
	Date - 03/06/11Staff noted a						
	bruise approximately 14x11 cm						
	(centimeters) on resident's upper						
	left arm during	g care. Resident was					
	admitted on 1/	22/11 with edema,					
	severe/extensi	ve bruising, a					
	fractured left h	numerus (arm), and a					
	fractured left h	nip as a result of a fall					
	prior to admiss	sion. The resident is					
	alert with shor	t term memory					
	impairment an	d occasional					
	confusion. Up	oon interview,					
	resident denies	s any injury to left					
	armThe Adı	ministrator and					
	Director of Nu	irsing were notified					
	as well as the	Physician and family.					
	The resident w	vas assessed for pain.					
	Interviews of s	staff working on this					
	wing were init	iated. In speaking					
	with the family	y, they stated that					

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 603 EAST NATIONAL HIGHWAY	
WASHINGTON NURSING CENTER WASHINGTON, IN47501	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY	(X5) COMPLETION DATE
(Resident #A) bruises very easily and has always done so. Preventive Measures Taken: The Director of Nursing or designee will monitor transfers of the resident and speak with Physical Therapy and Occupational Therapy and Occupational Therapy to try to determine a cause. The resident is to have a CBC (complete blood count) and X-ray done on 3/7/11. This report copy was the "initial Report." A copy of a "FAX/INCIDENT REPORT" form was provided by the DON on 03/17/11 at 1:00 p.m. This report was a repeat of the above incident on 03/06/11. This report had additional information which included, "During investigation period, resident reported that one employee was 'rough' with her and had used her arms to transfer her causing pain in arms and resident stated that she was uncomfortable with this Q.M.A. (Qualified Medical Assistant) (CNA #3 was also a	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155145	B. WIN		03/17/2011		011
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE ST NATIONAL HIGHWAY		
WASHINGTON NURSING CENTER				WASHIN	NGTON, IN47501		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	QMA) providi	ng ADL care on her.					
	This was report	rted to have occurred					
	on the morning	g of 3/9/11. Further					
	investigation i						
	allegation dire	ctly correlates with					
	the bruise on 1	eft upper arm.					
		physical therapy,					
	1	nd co-worker were					
	completed." This report copy was						
	the "Follow-up Report."						
	A copy of a fo OF DISCIPLE dated 03/09/11 termination of indicated, "# allegation of v physical misco resident causin List of prior w file and date. 2/9/11Failur other expectat et behavior set Handbook. Unprofessional behavior aroun	rm titled "NOTICE NARY ACTION," 1, indicated 1 CNA #3. The form 1 Repeated erbal et (and)					

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 603 EAST NATIONAL HIGHWAY WASHINGTON NURSING CENTER WASHINGTON, IN47501 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE CON	(X3) DATE SURVEY COMPLETED 03/17/2011	
WASHINGTON NURSING CENTER (X4) ID PREFIX TAG may result in termination. Describe in detail information you have available which supports taking the above course of action(Resident 603 EAST NATIONAL HIGHWAY WASHINGTON, IN47501 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
(X4) ID PREFIX TAG may result in termination. Describe in detail information you have available which supports taking the above course of action(Resident		
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) may result in termination. Describe in detail information you have available which supports taking the above course of action(Resident	(X5)	
may result in termination. Describe in detail information you have available which supports taking the above course of action(Resident	OMPLETION DATE	
available which supports taking the above course of action(Resident		
above course of action(Resident		
#A's) allegations of physical et		
verbal inappropriateness (with) same resident currently having new		
bruising of right arm. Resident		
expresses fear of employee"		
expresses rear or employee		
Review of Resident #A's clinical		
record on 03/17/11 at 11:25 a.m.		
indicated the following:		
Resident #A had diagnoses which		
included, but were not limited to,		
chronic obstructive pulmonary		
disease, osteoarthritis, dementia,		
history of falls, left hip fracture		
1/19/11, peripheral vascular		
disease, chronic oxygen use, and		
intra cerebral bleed.		
An MDS (minimum data set)		
assessment, dated 01/28/11,		
indicated Resident #A's cognitive		
status was moderately impaired and		
Resident #A required extensive		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	155145 B. WING			03/17/2011			
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF PROVIDER OR SUPPLIER				1	ST NATIONAL HIGHWAY		
	GTON NURSING C			<u>L</u> .	NGTON, IN47501		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
	assistance with	n transfers, bathing,					
	and toileting.	, 0,					
	S						
	A copy of a po	licy titled "Hoosier					
	Enterprises Pro	ocedure Resident					
	Abuse" was pr	ovided by the DON					
	on 03/17/11 at	11:00 a.m. This					
	policy indicate	ed, "Purpose: To					
	assure appropr	riate interventions are					
	in place and fo	ollowed if resident					
	abuse is suspec	cted or					
	identifiedPro	ocedure: If resident					
	abuse, or suspi	icion of abuse is					
	reported: 1. T	The resident(s)					
	involved in the	e incident will be					
	removed from	the situation at					
	onceThe ind	ividual who					
	witnessed the	incident shall					
	immediately n	otify a charge nurse					
	of the nursing	unit which the					
	resident occup	ies. If this is not					
	feasible due to	circumstances, the					
	individual shal	ll be responsible to					
	notify any other	er nurse currently on					
	duty. The char	rge nurse will					
	examine the re	esident involved to					
	determine if pl	hysical injuries have					
	occurred and t	heir extent. The					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145			(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/17/2011	
NAME OF PROVIDER OR SUPPLIER WASHINGTON NURSING CENTER			STREET A	ADDRESS, CITY, STATE, ZIP CODE ST NATIONAL HIGHWAY NGTON, IN47501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION
	the facility Ad Director of Nu immediately implicated in be removed fr once and will until an invest completed"	Any staff member the alleged abuse will om the facility at remain suspended igation is			